

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8111 S EMERSON AVE INDIANAPOLIS, IN 46237</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00155878, Unsubstantiated; lack of sufficient evidence.</p> <p>Date of survey: 10/8/14</p> <p>Facility number: 004972</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Franciscan St. Francis Health-Indianapolis is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules.</p> <p>QA: cloughlin 10/16/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE